



# Olive Tree Counseling, Inc.

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mark all of the items below that apply. Write in any clarifying remarks**

- Anger, Rage \_\_\_\_\_  
 Anxiety, nervousness, worry \_\_\_\_\_

- \_\_\_\_\_ I feel restlessness or keyed up on edge frequently      \_\_\_\_\_ I have feelings of irritability  
\_\_\_\_\_ I am easily fatigued      \_\_\_\_\_ I have muscle tension  
\_\_\_\_\_ I have difficulty concentrating or my mind going blank      \_\_\_\_\_ I experience sleep disturbance  
\_\_\_\_\_ I fear or avoid social situations

I have experienced these feelings for \_\_\_\_\_6mo      \_\_\_\_\_1year      \_\_\_\_\_2 years      \_\_\_\_\_since childhood

- Attention, concentration, distractibility  
 Career concerns, goals, and choices  
 Codependence  
 Confusion  
 Custody of children  
 Decision making, indecision, mixed feelings, putting off decisions  
 Delusions (false ideas)  
 Depression \_\_\_\_\_

- \_\_\_\_\_ I feel sad most of the day, nearly every day      \_\_\_\_\_ I feel low energy or fatigue  
\_\_\_\_\_ I have a poor appetite, or I overeat      \_\_\_\_\_ I experience feelings of low self esteem  
\_\_\_\_\_ I have trouble sleeping or I sleep a lot      \_\_\_\_\_ I experience feelings of hopelessness  
\_\_\_\_\_ I have poor concentration or difficulty making decisions      \_\_\_\_\_ I have had a significant weight loss or gain  
\_\_\_\_\_ I have feelings of committing suicide      \_\_\_\_\_ I feel like dying

I have experienced these feelings for \_\_\_\_\_6mo      \_\_\_\_\_1yr      \_\_\_\_\_years      \_\_\_\_\_since childhood

- Eating problems – Overeating, under eating, no appetite (see also “Weight and diet issues”)  
 I have used diuretics, laxatives, or induced vomiting       I have been diagnosed with an eating disorder  
 I have difficulty maintaining my body weight       I eat food for comfort when I am upset or lonely  
 I am often disturbed by my body’s shape or weight       I binge eat

- Emptiness  
 Exercise: How often/What type \_\_\_\_\_  
 Envy  
 Failure  
 Fatigue, tiredness, low energy  
 Fears, phobias  
 Financial or money troubles, debt, impulsive spending, low income  
 Friendships – None or limited supportive friendships  
 Forgiveness- I have a difficult time forgiving others  
 Gambling  
 Grieving, mourning, deaths, losses, divorce  
 Guilt  
 Headaches, other kinds of physical pains \_\_\_\_\_  
 Housework/chores - quality, schedules, sharing duties  
 I pull out my hair and there is noticeable hair loss  
 I sometimes feel a sense of tension until I pull out my hair and/or I feel a sense of relief after I pull out my hair

- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Loneliness
- Marital conflict:
 

<input type="checkbox"/> Distant/coldness	<input type="checkbox"/> Infidelity/Affair	<input type="checkbox"/> Remarriage
<input type="checkbox"/> Disappointments/Discontent	<input type="checkbox"/> Lack of communication	<input type="checkbox"/> Value/Belief System differences
<input type="checkbox"/> Parenting style differences	<input type="checkbox"/> Difference in sexual desire	<input type="checkbox"/> Pornography issues
<input type="checkbox"/> Physical or Emotional Intimacy	<input type="checkbox"/> Emotional Neglect or Abuse	<input type="checkbox"/> Domestic Violence

- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Obsessions/ Compulsions
 

<input type="checkbox"/> I have recurrent or persistent thoughts	<input type="checkbox"/> I experience images or impulses that are intrusive
<input type="checkbox"/> I feel anxiety	<input type="checkbox"/> I ignore or suppress thoughts, urges, or images
<input type="checkbox"/> I repeat behaviors (i.e. washing hands, checking, ordering)	<input type="checkbox"/> I experience anxiety if I don't repeat behaviors
- Oversensitivity to rejection
- Panic or anxiety attacks
 

<input type="checkbox"/> palpitations, pounding of or increased heart rate	<input type="checkbox"/> Sweating	<input type="checkbox"/> trembling or shaking	<input type="checkbox"/> nausea	<input type="checkbox"/> fear
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> feeling of choking	<input type="checkbox"/> chest pain/discomfort	<input type="checkbox"/> dizziness	<input type="checkbox"/> fear of losing control
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Pregnancies: How many \_\_\_\_\_ Losses \_\_\_\_\_ Terminations \_\_\_\_\_ Difficulties \_\_\_\_\_
- Problems associated with prescriptions medications, over-the-counter medications
- Procrastination, work, inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- Self-centeredness
- Self-esteem, Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Sometimes I see or hear things others do not hear or see
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts: Describe \_\_\_\_\_
- Suicide attempt: Describe \_\_\_\_\_
- Homicidal thoughts or attempts: Describe \_\_\_\_\_
- Temper problems, self-control, low frustration tolerance
- Thought disorganization
- Threats, violence
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- No one could really love me as I am
- I must be right or perfect to be ok

- I am basically a bad, unworthy person
- Internet use: hours per day do you engage in: gaming \_\_\_\_\_ surfing\_\_\_\_\_ YouTube/etc.\_\_\_\_\_ Facebook/etc.\_\_\_\_\_ Other \_\_\_\_\_

- Sex is my most important need or sign of love
- My needs are never going to be met if I have to depend on others
- I have trouble with authority figures
- I dislike taking instructions or having someone tell me what to do
- I have in the past or am currently cutting myself
- Alcohol or drug use over the past 12 months:
  - Have you gotten into trouble at home, at school or in the community, because of your drinking, using drugs or inhalants?
  - Have you missed school or work because of using alcohol, drugs or inhalants?
  - In the past year have you ever had 6 or more drinks at any one time?
  - Have you done harmful or risky things when you were high?
  - Do you think you might have a problem with your drinking, drug or inhalant use?
  - When using alcohol, drugs or inhalants have you done things without thinking, and wished you had not done them later?
  - Do you miss family activities, after school activities, community events, traditional ceremonies, potlatches, or feasts because of using alcohol, drugs or inhalants?
  - Does anyone close to you worry or complain about your using alcohol, drugs or inhalants?
  - Have you lost a friend or hurt a loved one because of your using alcohol, drugs or inhalants?
  - Do you use alcohol, drugs or inhalants to make you feel normal?
  - Does it make you mad if someone tells you that you drink or use drugs or inhalants too much?
  - Do you feel guilty about your alcohol, drug or inhalant use?

**Medical: Personal and Family of Origin**

Name of Personal Family Physician \_\_\_\_\_

- Do you have any allergies? No Yes if yes, please describe \_\_\_\_\_
- How would you describe your health/medical status? Excellent good fair poor
- Please describe any chronic / current medical conditions \_\_\_\_\_

Please list any medications you are taking for these conditions \_\_\_\_\_

- Please describe any past or present psychiatric, counseling or drug / alcohol treatment you have received

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Please list any psychiatric medications you have taken in past or are currently taking

Medication Name	When/From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- I am at low medium high risk for HIV
- I have been diagnosed with TB
- I have had a blow to the head that caused me lose consciousness
- I have received an injury that caused vision and / or hearing loss
- Did your father or his parents have any medical or psychological problems? No Yes if yes, please describe

- I am at low medium high risk for Hepatitis
- I have been treated for TB
- I have had a blow to the head that caused a concussion

- Did your mother or her parents have any medical or psychological problems? No Yes if yes, please describe

**Your Children:**

Name	Gender	Age	Who do they live with	Describe your relationship with them
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Family History:**

1. Where were you born and raised? How many siblings do you have?

\_\_\_\_\_

2. Which of these words best describes your relationship with your parents as a child?

Mother: \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic  
Father: \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic

3. Which of these words best describes your relationship with your Siblings?

Name of sibling: \_\_\_\_\_ \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic  
Name of sibling: \_\_\_\_\_ \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic  
Name of sibling: \_\_\_\_\_ \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic  
Name of sibling: \_\_\_\_\_ \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic  
Name of sibling: \_\_\_\_\_ \_\_\_ Warm \_\_\_ Loving \_\_\_ Distant \_\_\_ Difficult \_\_\_ Supportive \_\_\_ Bonded \_\_\_ Attached \_\_\_ Chaotic

4. List two positive things your parents taught you when you were growing up: \_\_\_\_\_

5. List two negative things your parents taught you: \_\_\_\_\_

6. Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Who? \_\_\_\_\_ Yes \_\_\_ No

7. Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Who? \_\_\_\_\_ Yes \_\_\_ No

8. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? Who? \_\_\_\_\_ Yes \_\_\_ No

9. Did you often feel that... no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other? \_\_\_\_\_ Yes \_\_\_ No

10. Did you often feel that... you didn't have enough to eat, had to wear dirty clothes, had no one to protect you Or your parents were too drunk or high to care for you or take you to the doctor if needed? \_\_\_\_\_ Yes \_\_\_ No

11. Were parents ever separated or divorced? How old were you? \_\_\_\_\_ Yes \_\_\_ No

12. When you were a child were any of your caregivers treated violently, often pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, or hit with something hard; or threatened with a gun or knife? Who? \_\_\_\_\_ Yes \_\_\_ No

13. Did you live with anyone who was a problem drinker or used street drugs? Who? \_\_\_\_\_ Yes \_\_\_ No

14. Was a household member depressed or mentally ill or did a household member attempt suicide? Who? \_\_\_\_\_ Yes \_\_\_ No

15. Did a household member go to prison? Who? \_\_\_\_\_ Yes \_\_\_ No

**Additional Lifetime losses / Adult OR Teen Traumas NOT previously noted.(Briefly describe)**

Abandonments \_\_\_\_\_

Assaults / Violent Events (including date or stranger rape) \_\_\_\_\_

Betrayals \_\_\_\_\_

Deaths \_\_\_\_\_

Separation or Divorces (How many? Briefly describe cause) \_\_\_\_\_

Threats / Intimidation (Briefly describe) \_\_\_\_\_

Please comment on any additional information in space below: